Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00885-200

Combined Assessment Program Review of the Alexandria VA Health Care System Pineville, Louisiana

June 14, 2012

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Alexandria VA Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Alexandria VA Health Care System, Pineville, LA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of April 23, 2012.

Review Results: The review covered nine activities. We made no recommendations in the following activities:

- Coordination of Care
- Environment of Care
- Mental Health Treatment Continuity

The facility's reported accomplishment was the "Not On My Watch" campaign to reduce risk of infection in the facility and improve infection prevention awareness among staff, patients, and visitors.

Recommendations: We made recommendations in the following six activities:

Colorectal Cancer Screening: Ensure patients with positive screening test results receive diagnostic testing within the required timeframe. Notify patients of biopsy results within the required timeframe, and document notification.

Point-of-Care Testing: Ensure employees who perform glucose point-of-care testing have competency assessed annually. Notify clinicians of critical test results requiring follow-up. Ensure oversight of point-of-care testing activities is provided and documented in accordance with local policy.

Nurse Staffing: Ensure facility and unit-based expert panels receive the required training. Reassess unit 7AS's target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Quality Management: Complete at least two preventive ethics improvement cycles each fiscal year.

Polytrauma: Ensure patients with positive traumatic brain injury screening results receive a comprehensive evaluation as outlined in Veterans Health Administration policy.

Follow-Up on Management of Test Results: Consistently communicate normal test results to patients within the specified timeframe.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following nine activities:

- COC
- CRC Screening
- EOC
- Follow-Up on Management of Test Results
- MH Treatment Continuity
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through April 23, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Alexandria VA Medical Center, Pineville, Louisiana,* Report No. 10-02982-73, January 24, 2011). We made a repeat recommendation in management of test results.

During this review, we presented crime awareness briefings for 81 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 189 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

"Not On My Watch" Campaign

The facility established the "Not On My Watch" campaign to increase awareness of and improve infection prevention practices among staff, patients, and visitors. The slogan can be found on shirts, caps, cups, pens, and educational materials to promote teamwork with the goal of reducing the risk of infection. Staff are introduced to the campaign during new employee orientation, and staff, patients, and visitors receive promotional items and educational materials with the campaign logo. The campaign has resulted in several accomplishments. These include 100 percent compliance with hand hygiene practices and contact precautions in multiple high-risk areas, no reported incidences of surgical site infections in the 4th quarter of FY 2011, and increased veteran influenza immunizations in FY 2012. The facility continues to monitor infection control practices using Infection Control Private Eyes, Hand Hygiene Observers, and MRSA[1] Champions. The program then uses the Plan, Do, Study, Act performance improvement model to address any identified issues.

[1] Methicillin-resistant *Staphylococcus aureus*.

Results

Review Activities With Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[2] Seven of the 14 patients who received diagnostic testing did not receive that testing within the required timeframe.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[3] Three patients had a biopsy, and none of their EHRs contained documented evidence of timely notification.

Recommendations

1. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

[2] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[3] VHA Directive 2007-004.

2. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 35 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of six patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
X	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
X	The facility complied with any additional elements required by local policy.

Competency Assessment. VHA requires the facility to complete and document competency assessments for all employees who perform glucose POCT.[4] The College of American Pathologists requires that competency be assessed annually. Eight employee competency records did not have documented evidence of annual competency assessment.

Test Results Management. VHA requires that critical results requiring follow-up be communicated to the responsible clinician to ensure that appropriate and prompt actions are taken if indicated.[5] For 2 of the 10 patients who had critical test results, there was no documented evidence of clinician notification.

[4] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
[5] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

POCT Oversight. Local policy requires semiannual review of POCT activities by the oversight committee. The oversight subcommittee did not maintain meeting minutes, and there was no documentation of oversight in FY 2011 parent committee minutes.

Recommendations

3. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed annually.

4. We recommended that processes be strengthened to ensure that clinicians are notified of critical test results requiring follow-up.

5. We recommended that processes be strengthened to ensure that oversight of POCT activities is provided and documented in accordance with local policy.

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (7AS) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
X	Members of the expert panels completed the required training.
	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
X	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Expert Panel Member Training. VHA requires that all members of the facility and unit-based expert panels complete chapter 1 of the Staffing Methodology National Training.[6] We were informed that none of the panel members had completed the required training.

Variance Between Actual Nurse Staffing and Target. VHA requires that the facility's target nursing hours per patient day be used to plan for staffing and to evaluate actual staffing.[7] Unit 7AS's average actual nursing hours per patient day were significantly below the target for the three groups of days reviewed, and nursing leadership we spoke with agreed that the target was higher than necessary to provide appropriate staffing.

Recommendations

6. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

7. We recommended that unit 7AS's nurse manager reassess the target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

[6] VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.
[7] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
X	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Integrated Ethics Improvement Cycles. VHA requires preventive ethics teams at each facility to perform, at a minimum, two improvement cycles each FY.[8] The facility had completed only one improvement cycle during FY 2011.

Recommendation

8. We recommended that processes be strengthened to ensure that at least two preventive ethics improvement cycles are completed each FY.

[8] Deputy Under Secretary for Health for Operations and Management, "Integrated Ethics Program Achievement: Goals and Reporting Requirements," memorandum, January 7, 2011.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, 10 EHRs of outpatients, and 10 training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results be offered further evaluation and treatment by clinicians with expertise in the area of TBI or that the facility submit an alternate plan for review by the VISN and the national Director of Physical Medicine and Rehabilitation for approval of arrangements outside of the directive.[9]

Of the 10 patients who screened positive for TBI, 1 patient refused further evaluation, and another patient had been evaluated previously. The remaining eight patients received the comprehensive evaluation at the facility. However, the physician performing the evaluations did not meet VHA criteria, and the facility did not have an alternate plan approved by the VISN and the national Director of Physical Medicine and Rehabilitation for the non-specialist to complete the evaluations.

[9] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.

Recommendation

9. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Review Activity With Previous CAP Recommendations

Follow-Up on Management of Test Results

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with communication of test results.

Communication of Normal Results. VHA requires facilities to communicate normal test results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[10] During the previous CAP review, only 10 of the 20 EHRs reviewed contained documented evidence of communication of normal test results to patients. In response to the recommendation from that review, the facility added a template field to the provider ambulatory care progress note and distributed instructions to providers regarding the communication of normal test results to patients within the specified timeframe. However, the facility reported monthly compliance for January, February, and March 2012 at only 80, 83, and 71 percent, respectively.

Recommendation

10. We recommended that processes be strengthened to ensure that normal test results are consistently communicated to patients within the specified timeframe.

[10] VHA Directive 2009-019.

Review Activities Without Recommendations

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 22 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected an intensive care, a medical/surgical, and an acute MH unit; the CLC; the emergency department; and the dental and SCI clinics. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or SCI outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.

Noncompliant	Areas Reviewed for MH Residential Rehabilitation Treatment Program (continued)
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's MH patients' transition from the inpatient to outpatient setting. Specifically, we evaluated compliance with selected requirements from VHA Handbook 1160.01 and VHA's performance metrics.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–26, for the full text of the Directors' comments.) We consider Recommendation 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[11]		
Type of Organization	Primary and secondary care health care system	
Complexity Level	3	
VISN	16	
Community Based Outpatient Clinics	Lafayette, LA Jennings, LA Natchitoches, LA Ft. Polk, LA	
Veteran Population in Catchment Area	FY 2011 – 83,795 FY 2012 – 81,182	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	110	
• **CLC/Nursing Home Care Unit**	160	
• **Other**	N/A	
Medical School Affiliation(s)	Tulane University School of Medicine	
• **Number of Residents**	98	
	Current FY (through February 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$79.2	$163.4
• **Medical Care Expenditures**	$59.4	$146.8
Total Medical Care Full-Time Employee Equivalents	1,180	1,171
Workload		
• **Number of Station Level Unique Patients**	20,461	29,489
• **Inpatient Days of Care:**		
o **Acute Care**	7,134	20,800
o **CLC/Nursing Home Care Unit**	11,997	32,668
Hospital Discharges	850	2,605
Total Average Daily Census (including all bed types)	155.5	146.5
Cumulative Occupancy Rate (in percent)	57.5	54.2
Outpatient Visits	89,104	250,279

[11] All data provided by facility management.

VHA Satisfaction Surveys

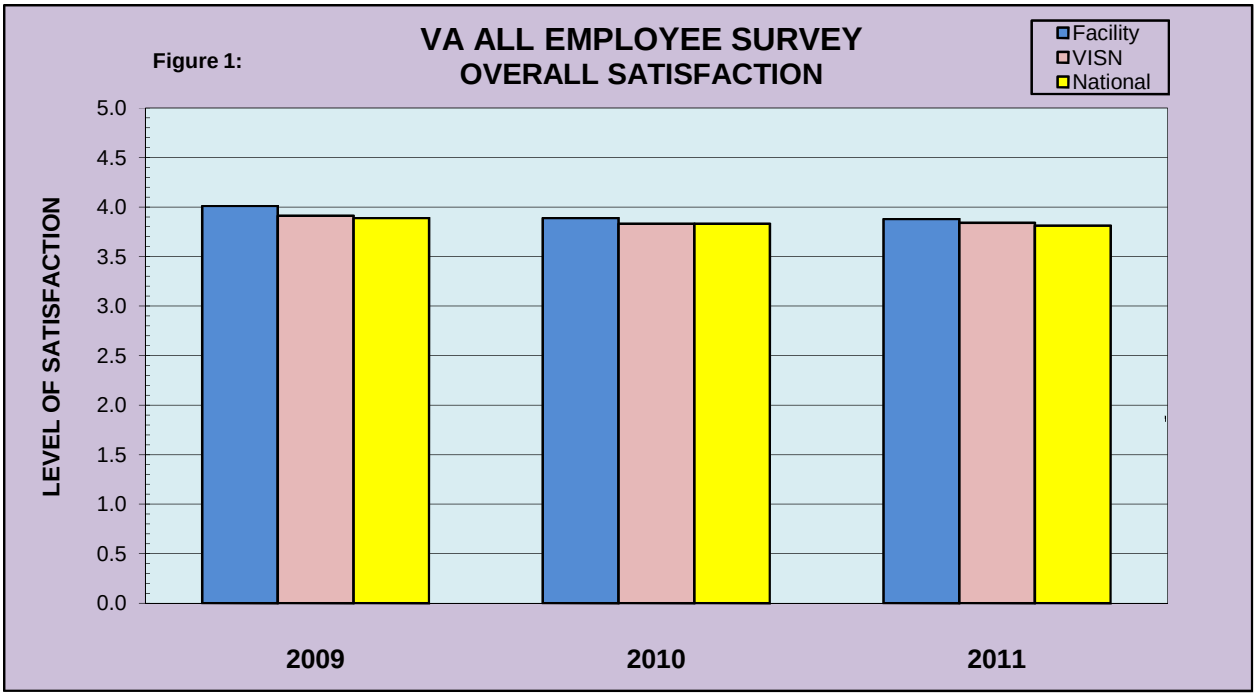
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	68.3	65.5	60.5	59.0	58.9	56.5
VISN	65.3	65.9	52.4	53.2	52.8	50.7
VHA	63.9	64.1	55.9	55.3	54.2	54.5

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[12] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[13]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	14.4	9.9	11.7	20.3	25.5	18.1
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[12] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[13] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2012

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Alexandria VA Health Care System, Pineville, LA (502/00)**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Service (VHA 10A4A4 Management Review)

1. The South Central VA Health Care Network submits the attached report in response to the draft report for the Combined Assessment Program Review of the Alexandria VA Health Care System, Pineville, LA.

2. If you have follow-up questions or require additional documentation to support the facility's response to the recommendations, please contact Reba Moore, VISN 16 Accreditation Specialist at 601-206-7022.

(*original signed by*:)
Rica Lewis-Payton, MHA, FACHE
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 24, 2012

From: Director, Alexandria VA Health Care System (502/00)

Subject: **CAP Review of the Alexandria VA Health Care System, Pineville, LA (502/00)**

To: Director, South Central VA Health Care Network (10N16)

1. Our responses addressing each recommendation are included in this draft report. Per your request, we also provided the actual March 2012 compliance data for the Management of Test Results (page 12) and verified the FY2012 Medical Care Budget (through February 2012) (page 18). This amount is low because it was only for 5 months (through February 2012) compared to the previous year's budget, which was for the whole year (12 months).

2. If you have any questions, please contact Portia McDaniel, RN, BSN, Chief, Performance Improvement, at (318) 466-2370.

(*original signed by*:)
Gracie Specks, MS, MBA
Director, Alexandria VA Health Care System (502/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: 12/31/12

Facility Response: The Acting Chief Specialty Care has completed a review of patients that are pending for CRC screening. Due to the high volume of patients requiring screening and the decline in resources, patients with positive Fecal Occult Blood test, and who are asymptomatic will be referred for fee basis care.

Recommendation 2. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: 7/31/12

Facility Response: The Chief, Specialty Care will develop a spreadsheet to track all patients who have a biopsy during CRC screening procedure. Veterans will be seen in clinic or notified by telephone contact by a surgeon or provider within 2 weeks following polypectomy or biopsy to get the pathological report and follow up recommendations. If either of these options are unsuccessful the results will be mailed to the patient. This will be documented in CPRS.

Recommendation 3. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have competency assessed annually.

Concur

Target date for completion: Completed

Facility Response: Competency training for 2012 was completed on 5/18/12 for those staff not meeting the annual requirements. Yearly competency training and evaluation will be coordinated through nursing education. Two power point presentations have been written for Glucose competency. The first one explains the use and operation of the AccuChek Inform Meter and the second one explains the cleaning of the meter and

documentation. Both power point presentations will be submitted to education so they can be included in the yearly training. Each power point has a test and the grade must be at least 80% for the nurses to pass. TMS training will be completed in January; operators will have until January 31st of each year to complete the training. If it has not been completed by January 31st, the operators will be locked out and will not be able to use the meters until training has been completed. Nursing education will also offer a skills fair in the month of January so operators can be observed as part of the competency assessment. This will include all RNs and LPNs. If the training and observations for competency are not completed the user will be locked out and will not be able to use the meters until all requirements are complete.

Recommendation 4. We recommended that processes be strengthened to ensure that clinicians are notified of critical test results requiring follow-up.

Concur

Target date for completion: 5/31/12

Facility Response: Critical results will be reviewed daily by the laboratory. Random results will be picked and checked in CPRS to make sure that critical notification has been sent to the physician. Any critical results that has documentation in RALS but no comment in CPRS will be sent to the head nurse. If RALS shows a nurse's comment, it will be checked against what is showing up in CPRS. One week per month will be checked to make sure criticals have been documented in the patient charts. Monthly reports will be sent to the head nurses and also the nurse executive.

Recommendation 5. We recommended that processes be strengthened to ensure that oversight of POCT activities is provided and documented in accordance with local policy.

Concur

Target date for completion: 9/28/12

Facility Response: Ancillary Testing Committee is a subcommittee of the Blood and Tissue Committee. A reporting schedule will be developed and added to the medical center policy. The chairperson will ensure that reports are addressed according to the schedule. Actions, updates and followup regarding Point of Care Testing will be included in the agenda and presented to the Committee. A review of the membership was completed by the Chief, Pathology & Laboratory Medicine Service. Ancillary Testing Committee consists of the following members:

Pathologist
Quality Manager or designee
Nursing Executive or designee
Chief, Prosthetics or designee
Ancillary Testing Coordinator
Diabetic Nurse Educator

A reminder will be sent to these members or their designee stressing attendance requirements for these meetings. Members who do not show up will be marked as non-compliant. At these meetings the Ancillary Testing Coordinator will give reports about POC testing for inclusion in the minutes. The last meeting was on March 30, 2012. The next meeting will occur no later than 9/28/12.

Recommendation 6. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: 7/1/12

Facility Response: The training has been sent out to individuals to complete and self report their completion, due to it not being available in TMS. It is review of a power point presentation. Self Certifications are due back to Chief Nurse no later than 6/30/12.

Recommendation 7. We recommended that unit 7AS's nurse manager reassess the target nursing hours per patient day to more accurately plan for staffing and evaluate the actual staffing provided.

Concur

Target date for completion: 8/1/12

Facility Response: The Chief Nurse will include unit 7AS target nursing hours per patient day in the staffing methodology data collection and review. These data elements and staffing plan will go through the unit based panel and the facility based panel for review and concurrence.

Recommendation 8. We recommended that processes be strengthened to ensure that at least two preventive ethics improvement cycles are completed each FY.

Concur

Target date for completion: 6/30/12

Facility Response: Preventative Ethics Coordinator, with assistance from IEPO and other members of Integrated Ethics Council, has ensured that 2 preventive ethics improvement cycles will be completed in FY12. Facility is on target for completion by 3rd Qtr FY 12.

Recommendation 9. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Concur

Target date for completion: 8/31/12

Facility Response: The facility has initiated processes to ensure that the provider has appropriate knowledge and skills to perform comprehensive evaluation for TBI. To date the Polytrauma Coordinator and the index provider have made contact with Dr. Cifu, National Director, PM&R Program Office; Dr. Scholten, Special Projects Director, PM&R Program Office; Dr. Sneed, Houston VA; Dr. Choudhury, Alexandria Health Care System, in efforts to have the provider complete the TBI mini-residency through the Houston PNS. Completion of this residency and other criteria defined by the National Office will certify the provider's ability to perform the evaluation for TBI.

Recommendation 10. We recommended that processes be strengthened to ensure that normal test results are consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: 6/15/12

Facility Response: The Acting Chief Primary Care will establish a process requiring the provider to add the PACT RN as an additional signer to clinic visit progress note when normal test results are not available for review with the patient. This will generate an alert and notification to the RN to mail the test results to the patient with 14 days of the visit. The nurse will document that the results were mailed to the patient.

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